



Comprehensive Care Management Corporation
A Member of the Beth Abraham Family of Health Services

1-877-226-8500 or TTY 1-800-650-2774 • 7 days a week from 8:00 AM through 8:00 PM

FOR OFFICE USE ONLY:	
Group No.	Plan Code
Potential Effective Date	PBP No.

Individual Enrollment Form

Please contact Comprehensive Care Management if you need information in another language or format

To Enroll in Comprehensive Care Management, Please Provide the Following Information:

Please check which plan you want to enroll in:

Direct Complete Plan \$33.30 per month **Direct Advantage Plan** \$33.30 per month

Direct Value Plan \$0 per month **Direct Choice Plan** \$33.30 per month

Last Name: _____ First Name: _____ Middle Initial: _____

Mr. Mrs.
 Ms.

Birth Date: (MM/DD/YYYY) _____ Sex: M F Home Phone Number: () _____ Alternate Phone Number: () _____

Permanent Residence Street Address: (P.O. Box is not allowed) _____

City: _____ State: _____ Zip Code: _____

Mailing Address (only if different from your Permanent Residence Address):
Street Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ **Phone Number:** _____ **Relationship To You:** _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card

-OR-

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

MEDICARE	HEALTH INSURANCE
Sample Only	
Name: _____	Sex: _____
Medicare Claim Number: _____ - _____ - _____	Effective Date: _____
HOSPITAL (PART A) _____	
MEDICAL (PART B) _____	

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty, we need to know how you would prefer to pay it. You can pay by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

You can pay your monthly plan premium by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare only pays a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Get a bill each month

Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered "yes" to this question and you don't need regular dialysis any more, or if you have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Comprehensive Care Management? Yes No

If "yes" please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____

Group # for this coverage: _____

3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
 If "yes" please provide the following information:
 Name of Institution: _____
 Address & Phone Number of Institution (number and street): _____
 If "no" do you live in the community but are eligible for nursing home level of care? Yes No

4. Are you enrolled in your State Medicaid program? Yes No
 If "yes" please provide your Medicaid number: _____

5. Do you or your spouse work? Yes No

Please choose the name of a Primary Care Physician (PCP), clinic or health center:	Are you already a patient of this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please choose the name of a Primary Care Dentist (PCD):	Are you already a patient of this PCD? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format;
 Spanish Russian Chinese Korean Audio tape, large print
 Please contact Comprehensive Care Management at 1-877-226-8500 if you need information in another format or language than what is listed above. Our office hours are 8 am to 8 pm seven days a week. TTY users should call 1-800-650-2774.

 **Please Read This Important Information** 

If you currently have health coverage from an employer or union, joining Comprehensive Care Management could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Comprehensive Care Management. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Comprehensive Care Management is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: November 15 – December 31 of every year), or under certain special circumstances.

Comprehensive Care Management serves a specific service area. If I move out of the area that Comprehensive Care Management serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Comprehensive Care Management, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Comprehensive Care Management when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Comprehensive Care Management coverage begins, I must get all of my health care from Comprehensive Care Management, with except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Comprehensive Care Management and other services contained in my Comprehensive Care Management Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR COMPREHENSIVE CARE MANAGEMENT WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Comprehensive Care Management, he/she may be paid based on my enrollment in Comprehensive Care Management.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the Comprehensive Care Management will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Comprehensive Care Management will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Comprehensive Care Management or by Medicare.

Signature: _____	Today's Date: _____
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If you are the authorized representative, you must sign above and provide the following information:

Name: _____
Address: _____
Phone Number: (_____) _____ - _____
Relationship to Enrollee: _____

If you are a translator or witness to the enrollment, please provide the following information:

Name: _____
Address: _____
Phone Number: (_____) _____ - _____
Relationship to Enrollee: _____

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____	Rep ID: _____
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Plan ID: _____	Effective Date of Coverage: _____
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ICEP/IEP	OEP	AEP	SEP (type): _____
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